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HEALTH FINANCE COMMISSION

Legislative Services Agency
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MEETING MINUTES[1]

Meeting Date:	**October 22, 2008**
Meeting Time:	**1:00 P.M.**
Meeting Place:	**State House, 200 W. Washington St., House Chamber**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**4**

Members Present: **Rep. Charlie Brown, Chairperson; Rep. Peggy Welch; Rep. John Day; Rep. Craig Fry; Rep. Phil Hoy; Rep. Carolene Mays; Rep. Scott Reske; Rep. Timothy Brown; Rep. Suzanne Crouch; Rep. Richard Dodge; Rep. David Frizzell; Sen. Patricia Miller, Vice-Chairperson; Sen. Gary Dillon; Sen. Beverly Gard; Sen. Marvin Riegsecker; Sen. Vaneta Becker; Sen. Connie Lawson; Sen. Ryan Mishler; Sen. Earline Rogers; Sen. Connie Sipes; Sen. Vi Simpson; Sen. Sue Errington.**

Members Absent: **Rep. Don Lehe.**

Prior to the adjournment of the Select Joint Commission on Medicaid Oversight, which was meeting immediately before the Health Finance Commission, Chairperson Charlie Brown announced a one-half hour delay for the start of the Health Finance Commission meeting.

Chairperson Brown called the fourth meeting of the Health Finance Commission to order at 1:40 PM. He announced that he would deviate from the agenda by hearing legislation proposed for the Commission's consideration first in the interest of maintaining a sufficient number of

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.in.gov/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

Commission members to make recommendations.

PD 3262- Home Health Care

On the request of the Chairperson, Ms. Kline, staff attorney, summarized the content of PD 3262. Senator Becker inquired about the specific information required to be reported by home health agencies and the process of data collection that would be used. Discussion followed regarding the amount and types of information collected from other providers such as nursing facilities and hospitals.

A motion was made and seconded to approve PD 3262. The motion was adopted by voice vote.

PD 3255 - Trauma Care Hospital Fund

A motion was made and seconded to approve PD 3255. The motion was adopted by unanimous voice vote.

PD 3261 - Self-directed Care

A motion was made and seconded to approve PD 3261. The motion was adopted by unanimous voice vote.

PD 3338 - Child Care Rules Concerning Lead Poisoning

Senator Gard summarized PD 3338 and in response to a question about enforcement authority suggested that the required rules could address that issue.

A motion was made and seconded to approve PD 3338. The motion was adopted by unanimous voice vote.

PD 3432 - Attracting Primary Care Physicians for Shortage Areas

A motion was made and seconded. The motion to approve PD 3432 was unanimously adopted by voice vote.

PD 3415 - Modernization or Privatization Contracts

Senator Becker explained the proposed legislation. Commission discussion followed regarding problems consumers have experienced as a result of the eligibility modernization project. (See Exhibit A.) FSSA Secretary, Mich Roob, explained that the agency's emergency response to disastrous flooding in numerous counties had disrupted the implementation of the contract. He pledged to continue working on the issue.

A motion was made and seconded to approve PD 3415. The Chairperson announced the motion was adopted following a voice vote.

Final Report Draft

A motion was made and seconded to approve the draft of the Final Report with the inclusion of the October 22, 2008, meeting testimony and the Commission's actions taken on the preliminary drafts. The motion was approved unanimously by voice vote.

Eligibility Modernization

Chairperson Brown announced that the discussion of PD 3415 had adequately covered the topic of eligibility modernization.

Indiana Check-Up / Healthy Indiana Plan Update

FSSA Secretary Mitch Roob, highlighted progress made in implementing various components of the Indiana Checkup program as well as Healthy Indiana Plan (HIP) application and enrollment statistics. (See Exhibit B.) Secretary Roob pointed out that of 29,350 enrolled participants in the HIP program, contrary to the original projections, 20,000, or 70%, have incomes below 100% of the federal poverty level and 63% are female, while the age distribution of enrolled participants is better than projected. He also pointed out that the map of approved HIP members by county demonstrates the enthusiasm for the program by the local hospitals and community mental health centers in each county that have been instrumental in marketing the program to eligible individuals.

In response to Commission questions, Secretary Roob discussed the reasons for applicants being denied coverage under the HIP program. (See "HIP Weekly Dashboard", page 15, Exhibit B.) Chairperson Brown asked if there should be changes made to the HIP program, such as the requirement that applicants not have had insurance coverage within six months. In response to a question about the exclusion of chiropractic services, the Secretary explained that in the first proposal for the HIP, dental and vision services had been proposed to be covered in supplemental insurance that exceeded the 5%-of-income cap imposed on HIP premiums. This proposal was not accepted by the federal Centers for Medicare and Medicaid Services during the waiver negotiations, so it was decided to offer coverage to more people rather than include these services in the benefit package. He added that chiropractic services are covered under the HIP plan if the insured is referred through the program.

In response to a question about how much money has been collected in cigarette tax revenue, Secretary Roob explained that the intent was to accumulate funds during the buildup of the program in order to provide funding for later years. He then said that about $124 M in cigarette tax has been collected and $24 M has been spent for HIP. Additional discussion followed regarding specific problems encountered with making HIP Power Account payments. Secretary Roob stated that there is no mechanism to make cash payments to the insurers, so FSSA has made arrangements with various utility companies to accept cash payments. He added that not all utility companies are participating in this program. Senator Becker stated she had heard from a neurologist in her district that had refused to participate in the HIP program due to a specific contract clause. She asked if there were other areas of the state where specialists are refusing to treat patients covered by HIP. She added that access to dental care in Medicaid in Vanderburgh County is compromised due to low reimbursement rates. (See Exhibit C.) Secretary Roob responded saying that specialist participation is more of a problem in the Medicaid program since reimbursement rates are lower than those associated with HIP.

When asked about the requirement that a HIP applicant must have been uninsured for at least six months, the Secretary clarified that Medicaid coverage is not considered to be insurance. There was discussion regarding the treatment of pregnancy for women enrolled in HIP and the link to Medicaid. Secretary Roob admitted that the mechanism for the movement of pregnant women from HIP to Medicaid is not yet operating smoothly. The Commission also discussed the enrollment of parental adults and non-parental adults. The HIP program limits participation of non-parental adults to 34,000. This group is already disproportionately represented. The Secretary said that the administration would have recommendations on how to deal with this issue before the session.

The Secretary reported that the Indiana Check-Up Plan Task Force is now meeting. He noted that the House appointments have not yet been made and that the task force composition did not include consumers as a represented group. The administration plans to appoint two consumer representatives. It was left to the members of the Commission to decide if they would like to change the statute to include consumers in the task force membership.

Indiana Check-Up Plan II

Secretary Roob reviewed a proposal to revise the Indiana Medicaid program. (See Exhibit D.) The goals of the plan that he referred to as Indiana Check-Up Plan II are to: (1) eliminate spend-down and expand full disability coverage to 200% of the federal poverty level, (2) provide automatic disability coverage to the SSI population, (3) expand the HIP program to cover more non-parental and parental adults, (4) implement the HIP premium assistance option for HIP participants, and (5) secure and maintain funding for the Indiana safety net. He highlighted several advantages of the goals including the elimination of the state's 209(b) status, the Medicaid spend-down, and duplication of the disability determination process that currently occurs. He added that the proposal would shift Disproportionate Share Hospital funding from the state hospitals to provide support for more non-parental adults in the HIP. The plan also proposes using the Upper Payment Limit funding stream and a hospital provider tax to increase Medicaid hospital reimbursement rates almost to the level of Medicare rates. The Secretary emphasized that this plan represents a concept only at this time. He stated that the financial information addressing potential sources and uses of funds presented on pages 7 and 8 of Exhibit C represent very preliminary estimates only.

Implementation of the HIP Premium Assistance Option

Secretary Roob reported that about 15 states currently have premium assistance programs. He reported that the programs tend to have high administrative expenses. FSSA has estimated that 30,000 individuals in Indiana might be eligible to participate in a premium assistance program. Premium assistance was not included in the Medicaid 1115 waiver for the HIP program. The Secretary brought up policy considerations that would need to be addressed such as whether all employer plans be subsidized or just some, and whether premium assistance be mandated. He added that there were other problems to be considered in any implementation of a premium assistance program, including how to deal with the HIP requirement for a six-month period without insurance coverage and with open enrollment time frames.

Commission discussion followed regarding the potential impact of the outcome of the presidential campaign on health care programs.

Participation of Unsubsidized Individuals in HIP

Secretary Roob reported that FSSA has not been able to figure out a way to allow the participation of unsubsidized individuals within the federal Medicaid waiver.

MCO Contract Pharmacy Carve-out

Secretary Roob explained that within the Medicaid program, pharmacy products are purchased in two ways. In Hoosier Healthwise and HIP, pharmacy products are included in the capitation rate paid to the managed care organizations (MCOs). All other pharmacy purchases are purchased on a fee-for-service basis and processed by a contracted pharmacy benefits manager (PBM). Medicaid direct purchases for prescription drugs are eligible for manufacturer rebates that may be for up to 38% of the cost of the drugs. The rebate availability means that prescription drugs cost more within the capitated HIP and Hoosier Healthwise programs. FSSA is proposing to remove the cost of prescription drugs from the capitated rates paid to the MCOs

in order to take advantage of the rebates. An initial estimate of the dollar amount of the rebates that might be available indicates a potential annual state-only savings of $30 M to $40 M. (See Exhibits E & F.)

Secretary Roob proposed that starting January 1, 2010, the pharmacy expenditures be removed from the calculated MCO capitation rate. The current Medicaid PBM would be used to process all the drug purchasing. He emphasized that the populations served by the MCOs are mostly pregnant women and children; disabled adults and children are already using the PBM claims processing for drug acquisitions. Secretary Roob concluded by stating that he does not believe this change would put any patients at risk and the associated savings would be good for taxpayers.

In response to a Commission question, Secretary Roob stated that removing the pharmacy expenditures from the capitated MCO rates could be done without legislative approval. Chairperson Brown asked if there was any testimony from drug manufacturers or their representatives. There was no response.

Joe Vanable, NAMI Indiana

Mr. Vanable stated that NAMI is interested in how the proposal would affect persons with mental illness. He stated that mental illness is treatable, but if there is no access to treatment there is a cost to patients and society. He added that if the pharmacy carve-out would impede access to mental health drugs, NAMI would have concerns.

Immunization Registry Evaluation

Penny Lewis, CHIRP Project Manager

Ms. Lewis gave a review of the Children and Hoosier Immunization Registry Program (CHIRP). (See Exhibit G.) Started in 2002, the CHIRP program is a free life-span immunization registry funded through a Centers for Disease Control grant. During the 2006 session, in response to some criticism, the Indiana State Department of Health (ISDH) was asked to identify efforts to make CHIRP easier to use. Ms. Lewis explained that the CHIRP system uses existing prepackaged software sold and used in eight other states. Additionally, ISDH conducts monthly user group meetings to identify problems and opportunities for improvements. There are currently about 4,000 users in Indiana. Ms. Lewis commented that the ISDH made efforts to reach parties that do not use CHIRP but had poor participation.

ISDH conducted a survey inside the CHIRP product in order to reach users only. Ms. Lewis reviewed the results of the user survey. She identified that 0.06% of respondents thought the system was difficult to use.

The system is capable of adding data from other sources to the records and can maintain records such as blood-lead testing results. CHIRP allows “view only” access for schools, day care providers, WIC, and other similar providers needing to check on the status of a child’s immunizations. The CHIRP system has data on over 3 million active patients with 27 million recorded vaccinations.

Ms. Lewis gave a demonstration of the CHIRP system.

Senator Dillon asked how the CHIRP system controls the access to the data. Ms. Lewis responded that data entry must be performed by a professional licensed by the state. She further explained that the system can track data by the person posting the data. In response to another question regarding hospitals’ use of the system, Ms. Lewis commented that the system

is voluntary. Rep. Welch commented that it would be helpful if hospitals would enter data regarding tetanus or pneumococcal immunizations given.

There being no further business to discuss, Chairperson Charlie Brown thanked the Commission members for their attendance and adjourned the meeting at 3:45 PM.